MOTION FILED
MAY 5 1999

No. 98-1526

In The Supreme Court of the United States

WOLFGANG SCHUG, M.D.,
Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows
Respondents.

On Petition For Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* FOR THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA SUPPORTING PETITIONER

GENE E. GODLEY
Counsel of Record
SHANNON H. RATLIFF, II
BRACEWELL & PATTERSON, L.L.P.
2000 K Street, N.W., Suite 500
Washington, D.C. 20006-1872
(202) 828-5800

Counsel for Amicus Curiae,
Physician Insurers Association of America

1988

No. 98-1526

In The

Supreme Court of the United States

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs surviving parents of Cody Burrows,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE*

The Physician Insurers Association of America hereby respectfully moves for leave to file the attached brief *amicus curiae* in the above-referenced case. The consent of the attorney for Petitioner has been obtained. However, the consent of the attorney for the Respondents was requested but refused. Accordingly, the Physician Insurers Association of America hereby moves for leave to file the attached brief *amicus curiae*.

The Physician Insurers Association of America represents doctor and dentist owned or operated professional liability insurers insuring approximately sixty percent of America's private practice physicians as well as dentists, hospitals and other health care providers. Accordingly, the Physician Insurers Association of America has a strong interest in the resolution of the current uncertainty that exists in the lower courts regarding the applicability of the state medical peer review privilege when physicians, hospitals or other health care providers are drawn into a federal forum when pendent state claims against them are permissively joined with a federal question.

Participating as *amicus curiae*, the Physician Insurers Association of America hopes to aid the Court in its consideration of the petition for a writ of certiorari by providing insight into the centrality of the medical peer review process to health care quality assurance, and the consequent need to ensure the integrity of the medical peer review privilege.

Respectfully Submitted,

GENE E. GODLEY
Counsel of Record
BRACEWELL & PATTERSON, L.L.P.
2000 K Street, N.W., Suite 500
Washington, D.C. 20006-1872
(202) 828-5800

Counsel for Amicus Curiae,
Physician Insurers Association
of America

TABLE OF CONTENTS

	Page
Interest of Amicus Curiae	1
Summary of Argument	3
Argument	4
Conclusion	14

TABLE OF AUTHORITIES

FEDERAL CASES

Page

Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970) 11

Century Southwest Cable Television, Inc. v. CIIF Associates, 33 F.3d 1068, 1071 (9th Cir. 1994) 7

Jaffee v. Redmond, 518 U.S. 1 (1996) 13

FEDERAL STATUTES

42 U.S.C. § 1395bb 8

Health Care Quality Improvement Act, 42 U.S.C.§§ 11101 *et seq.* 6,7

FEDERAL REGULATIONS

42 C.F.R. § 482.22 (1999) 8

STATE STATUTES

CAL. BUS. & PROF. CODE § 805 (West 1998) 11

GA. CODE. ANN. § 31-7-15 (West 1998) 8

OTHER AUTHORITIES

AMERICAN MEDICAL ASSOCIATION, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 1997 9

Atul Gawande, *Annals of Medicine: When Doctors Make Mistakes*, THE NEW YORKER, February 1, 1999 at 40 12

B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151 (1984) 12

H.R. REP. NO. 99-903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384 7

JOINT COMMITTEE ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUALS FOR HOSPITALS (1996) 8

Daniel P. Kessler and Mark P. McClellan, *The Effect of Malpractice Pressure on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81 (1997) 9

NATIONAL COMMISSION FOR QUALITY ASSURANCE, 1998 STANDARDS FOR CERTIFICATION OF PHYSICIAN ORGANIZATIONS (1998) 8

Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1025-31 (1990) 3

PHYSICIAN INSURERS ASSOCIATION OF AMERICA, MEDICAL MALPRACTICE CLAIM EXPENSES: ANNUAL INCREASES OUTPACING INDEMNITY GROWTH (1997) 10

PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS (1995) 9

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, STATE MEDICAL BOARDS AND QUALITY-OF-CARE CASES: PROMISING APPROACHES (1993) 10,11

UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL LIABILITY: IMPACT ON HOSPITAL AND PHYSICIAN COSTS EXTENDS BEYOND INSURANCE (1995) 10

Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.J. & MED. 7 (1999) 12

In The

Supreme Court of the United States

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs surviving parents of Cody Burrows,

Respondents.

BRIEF FOR THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF AMICUS CURIAE [1]

---

[1] Pursuant to Rule 37.6 of the Rules of this Court, counsel hereby certifies that the brief submitted on behalf of amicus curiae Physician Insurers Association of America was not authored in whole or in part by counsel for a party, and no person or entity other than the Physician Insurers Association of America and its members has made a monetary contribution to the preparation of this brief.

The Physician Insurers Association of America ("PIAA")is a non-profit trade association comprised of more than 60 professional liability insurance companies owned and/or operated by doctors and dentists. The membership of the PIAA includes forty-seven physician and dentist owned and/or operated companies in the United States, four reinsurance companies, and nine international members in Australia, France, Great Britain, and the Netherlands. Collectively, these companies insure approximately sixty percent of America's private practice physicians as well as dentists, hospitals and other health care providers. The focus of the PIAA's activities is on issues and developments that are likely to impact member companies, the availability and affordability of professional liability insurance, and the ability of the policyholders of the member companies to deliver quality health care. In this role, PIAA has sponsored numerous research, educational, legislative and regulatory initiatives aimed at improving the quality of and access to health care while reducing costs.

Because the medical peer review system is the single most important risk management mechanism for ensuring a continued high quality of medical care, PIAA is extremely concerned that any uncertainty regarding the availability of the state medical peer review privileges regardless of forum could have a severe chilling effect on peer review, and consequent adverse effects for health care quality and cost of care. The PIAA would urge the Court to grant Petitioner's Petition for Writ of Certiorari to resolve the important question of the applicability of state medical peer review privileges in federal question cases with pendent state law claims.

SUMMARY OF ARGUMENT

Over the last several decades, the health care delivery system in the United States has undergone a dramatic transformation with the rise of managed care and the transformation of hospitals and medical groups into much more sophisticated entities. Methods of promoting quality assurance and protecting patient safety reflect this transformation as well. Whereas the individual physician was once the only guarantor of the quality of care provided, now the individual physician is complemented by a second tier of quality assurance in the form of the medical peer review committee that exists in hospitals, medical groups, health maintenance organizations ("HMO's"), medical societies and other physician organizations.[2] Medical peer review has become the central quality assurance mechanism for monitoring the competence of physicians and ensuring that patients receive the highest quality of medical care. Medical peer review has been recognized as essential to health care quality by accrediting bodies, state medical licensing boards, state legislatures and the United States Congress. Medical peer review provides a superior mechanism to reliance on the medical malpractice system or overwhelmed and often underfunded state medical licensing boards.

In order to foster vigorous peer review, these proceedings must remain privileged and practitioners must be able to rely on the privilege being applied with certainty. Practitioners and policymakers alike have concluded that the peer review

---

[2]*See* Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1025-31 (1990) (describing evolution of hospital quality assurance).

privilege is essential to the effective functioning of the medical peer review process. Indeed, all fifty states and the District of Columbia provide some level of protection from disclosure or discovery of peer review records. The policies served by the medical peer review privilege will be undermined if practitioners cannot be certain that the peer review privilege will not be vitiated purely because they are fortuitously drawn into a federal forum when pendent state claims lodged against them as co-defendants are permissively joined with a federal question. Continued uncertainty in this area merits review by this Court.

ARGUMENT

1. Medical Peer Review is the Prevailing Method of Quality Assurance in the U.S. Health Care System

A. Medical Peer Review: How Does It Work?

Today medical peer review represents the most pervasive form of quality control at all levels of the U.S. health care system. Medical peer review is utilized by hospitals, HMO's, preferred provider organizations ("PPO's"), medical groups, medical societies and other health care entities to ensure quality care.

The medical peer review process performs numerous functions within the context of quality assurance. First, medical peer review serves a "gatekeeper" function in assessing the qualifications and competence of physicians through the credentialing process. The credentialing process typically employs peer review to review educational

qualifications, clinical competence, professional conduct, physical and mental health of practitioners seeking to be licensed or seeking to join hospital medical staffs, medical groups, HMO's, managed care panels, medical associations or societies, and a host of other professional organizations for physicians. In hospitals, the medical peer review system allows for ongoing monitoring to ensure that a physician maintains the necessary skills and professional competence for the clinical privileges he/she possesses and plays an important role in the biennial physician reappointment process.

Second, medical peer review provides an ongoing quality assurance mechanism to identify problems with the quality of care received in particular cases. Cases identified through quality assurance safeguards are typically reviewed by departmental or specially constituted peer review committees to assess the quality of care provided and direct necessary remedial actions or monitoring. Finally, medical peer review serves as an important educational tool. The purpose of the medical peer review committee process is to provide a forum for frank and open discussion among colleagues for the purpose of educating all involved. Often peer review will involve difficult cases or unexpected medical outcomes. Providing a forum for candid assessments of these cases allows practitioners to learn from one another so that the best quality patient care can be provided in such situations. Thus, the medical peer review system serves as a vital educational tool for physicians as well as being a credentialing and disciplinary device. While it may not be possible to produce a system that will allow for error-free quality of care, medical peer review presents the best mechanism for addressing quality of care issues as they arise.

B. Medical Peer Review Has Been Recognized as Essential to Health Care Quality By Congress, and is Required for Accreditation, Participation in Federal Programs and by Many States

While congressional recognition of the importance of peer review to ensuring quality care can be traced as far back as the establishment of Professional Standards Review Organizations ("PSRO's") in 1972 to review the quality of care being received by inpatients participating in the Medicare program, the central role of medical peer review has been firmly established most recently by congressional enactment of the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11101-52. In enacting this legislation, Congress expressly found as follows:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any state.
>
> ...
>
> (3) This nationwide problem can be remedied through effective professional peer review.
>
> ...

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

Id. at § 11101. Congress attached sufficient importance to the peer review process as a means to ensure health care quality that it saw fit to make express findings regarding the essential function of peer review and to provide immunity from civil actions based on peer review when conducted within certain parameters.[3] *See Id.* at 11111-12.

In addition to congressional recognition, medical peer review is so essential to quality care as to merit its inclusion in the standards that must be met for the accreditation of health care organizations. The accreditation of most health care organizations providing health care in the United States, including hospitals, health care networks, PPO's and managed care organizations ("MCO's"), is performed by nongovernmental entities that have adopted standards for accreditation that are widely recognized throughout the health

---

[3]Although some may contend that the fact that Congress did not enact a federal peer review privilege at the time that it enacted other peer review protections under HCQIA suggests congressional intent to deny such a privilege, a review of the legislative history, *see* H.R. REP. NO. 99-903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, reveals that Congress did not consider—much less consider and reject—such a privilege as required to infer legislative intent to deny the privilege in a federal forum. *See, e.g., Century Southwest Cable Television, Inc. v. CIIF Associates*, 33 F.3d 1068, 1071 (9th Cir. 1994) (citing *Russello v. United States*, 464 U.S. 16, 23-24 (1983)) (stating that congressional intent to reject provision can be presumed where Congress includes, but subsequently deletes provision from legislation).

care industry.[4] The Joint Commission on the Accreditation of Health Care Organizations ("JCAHO") is the primary organization involved in the accreditation of hospitals, and also provides accreditation for health care networks and PPO's. JCAHO's accreditation standards have recognized the vital importance of peer review to ensuring the quality of medical care, and consequently require that hospitals and other health care entities maintain peer review systems in order to receive accreditation. *See* JOINT COMMITTEE ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS MS 1 (1996). The National Committee for Quality Assurance ("NCQA"), the primary accrediting entity for managed care organizations ("MCO's"), similarly requires that accredited entities have in place mechanisms to monitor, evaluate and improve the quality of care received by the MCO's enrollees. *See* NAT'L COMM. FOR QUALITY ASSURANCE, 1998 STANDARDS FOR CERTIFICATION OF PHYSICIAN ORGANIZATIONS.

In addition to being required to secure accreditation, the implementation of an effective medical peer review system is a condition of participation in the federal Medicare program. *See* 42 C.F.R. § 482.22 (1999). Moreover, it has been the considered judgment of numerous state legislatures that medical peer review should be required by statute for entities operating within the state in order to ensure adequate care. *See, e.g.*, GA. CODE. ANN. § 31-7-15 (1998).

---

[4]Indicative of the standard setting nature of these entities is the fact that JCAHO accreditation allows participation in the federal Medicare program without additional certification, *see* 42 U.S.C. § 1395bb, and numerous states similarly recognize JCAHO accreditation for licensure purposes.

D. Medical Peer Review is the Best Available Mechanism for Ensuring Health Care Quality

While the medical malpractice system and state medical licensing boards provide two other methods of addressing quality assurance in the practice of medicine, there are substantial shortcomings with each of these approaches, particularly with respect to the ability to provide ongoing monitoring of the quality of care.

According to research conducted by the American Medical Association, 8% of all physicians had at least one professional liability claim lodged against them in 1995 with higher-than-average claim rates for particular specialties and in certain regions of the country. *See* AMERICAN MEDICAL ASSOCIATION, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 1997 at 40-41. Yet the medical malpractice system has been shown to be a flawed and costly mechanism for addressing quality of care issues or compensating injured patients.

With respect to the medical malpractice system as a control on the quality of care, commentators have noted that the current liability system is ill-suited to that goal and may in fact impose additional costs on the health care system due to the practice of "defensive medicine." *See* Daniel P. Kessler and Mark B. McClellan, *The Effect of Malpractice Pressure on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81, 81 (1997); PHYSICIAN PAYMENT REVIEW COMMISSION, 1995 ANNUAL REPORT TO CONGRESS at 318-19 (describing costs associated with current medical liability system). In addition, reliance on the medical malpractice system carries additional societal costs in the

form of higher costs to hospitals and other health care entities associated not only with increased insurance premiums, but also with additional costs related to claims management and settlement. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL LIABILITY: IMPACT ON HOSPITAL AND PHYSICIAN COSTS EXTENDS BEYOND INSURANCE (1995). These costs are ultimately passed on to consumers and taxpayers in the form of higher health insurance premiums. Therefore, the medical malpractice system alone is unlikely to provide an effective mechanism for assuring quality care by physicians.

Nor has the medical malpractice system been shown to provide an effective system of compensating patients harmed by negligent medical care. The medical malpractice system's inefficiencies result in average delays of four to five years in disposing of medical malpractice claims. *See* Kessler & McClellan, *supra*, at 81. In addition, research shows that the medical malpractice claimant typically receives only half of the amount of indemnity and expenses incurred to compensate the injured party. PHYSICIAN INSURERS ASSOCIATION OF AMERICA, MEDICAL MALPRACTICE CLAIM EXPENSES: ANNUAL INCREASES OUTPACING INDEMNITY GROWTH (1997) at 6.

While state medical licensing boards serve an important function, they too suffer from limitations in their ability to provide the type of oversight and monitoring provided by the medical peer review system. A report prepared by the Department of Health and Human Services' Office of the Inspector General noted that "[q]uality-of-care cases are among the most difficult types of cases for state medical boards to address." *See* U.S. DEPT. OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, STATE

MEDICAL BOARDS AND QUALITY-OF-CARE CASES: PROMISING APPROACHES at i (1993). Moreover, the report noted that state medical boards are often limited in their ability to pursue such cases by limited funding and resources. *Id.* at iv. Therefore, while state medical licensing boards serve an important function, they are hampered in their ability to fulfill the role of active and effective peer review. In fact, many state medical licensing boards depend on reports generated from medical peer review settings to serve as an initial screening and investigatory tool. *See, e.g.*, CAL. BUS. & PROF. CODE § 805 (West 1998). If peer review were weakened due to uncertainty surrounding the application of the peer review privilege, state medical licensing boards would also be adversely affected.

2. Medical Peer Review Privilege is Essential to the Effective Functioning of the Peer Review Process

While the oft-quoted passage from *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970), is perhaps the most frequently cited rationale for the medical peer review privilege, more telling perhaps is the following description offered by a practicing physician:

> The tort system makes adversaries out of patient and physician, and pushes each to offer a heavily slanted version of events...
>
> ...
>
> There is one place, however, where doctors can talk candidly about their mistakes, if not with patients, then at least with one another. It is called the Morbidity and Mortality Conference—or, more simply, M. & M.—and

> it takes place, usually once a week, at every teaching hospital in the country. This institution survives because laws protecting its proceedings from legal discovery have stayed on the books in most states, despite frequent legal challenges. Surgeons, in particular, take the M. & M. seriously. Here they can gather behind closed doors to review the mistakes, complications, and deaths that occurred on their watch, determine responsibility, and figure out what to do differently next time.

Atul Gawande, *Annals of Medicine: When Doctors Make Mistakes*, THE NEW YORKER, February 1, 1999, at 40, 48. While some commentators have suggested that the medical peer review privilege is not necessary to secure the participation of physicians in the peer review process,[5] the succinct statement above captures the impact of the privilege on physicians' perceptions of peer review which will be the determining factor in whether effective peer review takes place. Moreover, the peer review privilege allows physicians to openly and candidly assess medical quality issues to prevent future patient injuries.

The necessity of providing a privilege to safeguard the effective functioning of the medical peer review process is the result of the considered judgment of fifty state legislatures and

---

[5]*See* B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 154-55 (1984) (suggesting that the absence of the privilege would not end effective peer review); *see also,* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit--Is It Time for a Change?*, 25 AM. J.L. & MED. 7 (1999) (suggesting that privilege will not necessarily remove reluctance to participate due to other disincentives not addressed by the privilege).

the District of Columbia (*see* Pet. App. F (collecting statutes)), all of which provide some type of protection against disclosure or discovery of peer review records. As this Court noted in *Jaffee v. Redmond*, 518 U.S. 1, 20 (1996) (citing *Trammel v. United States*, 445 U.S. 40, 48-50 (1980), and *United States v. Gillock*, 445 U.S. 360, 368, n. 8 (1980)), "[w]e have previously observed that the policy decisions of the States bear on the question whether federal courts should recognize a new privilege or amend an existing one." This Court further explained with respect to the patient-psychotherapist privilege that:

> any State's promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in federal court. Denial of the federal privilege therefore would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.

Jaffee at 20 (footnote omitted).

Among the questions presented for review by Petitioner is the question of whether a codefendant against whom only state claims are asserted and who has been permissively joined in a federal question case will nonetheless lose the protection of the state medical peer review privilege. Due to the nature of this issue, the applicability of the state medical peer review privilege in federal question cases has not received extensive treatment in the Circuit Courts. However, as Petitioner adequately sets forth in his petition for writ of certiorari, there is significant disarray in the district courts on this issue that merits further review by this Court. Both to provide needed certainty to physicians and in order to avoid

frustrating the purposes of state legislation, this Court should grant the petition for a writ of certiorari to resolve this question.

CONCLUSION

The petition for writ of certiorari should be granted because of the significant national importance of the question presented for review.

Respectfully submitted,

GENE E. GODLEY
Counsel of Record
SHANNON H. RATLIFF, II
BRACEWELL & PATTERSON, L.L.P.
2000 K Street, N.W., Suite 500
Washington, D.C. 20006-1872
(202) 828-5800

Counsel for Amicus Curiae,
Physician Insurers Association
of America

May 1999